PREVIOUS EDITION IS NOT USABLE NSN 7540-00-634-4276

MEDICAL RECORD — PRENATAL AND PREGNANCY

DATE

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE INITIAL
STREET ADDRESS	CITY	STATE

TELEPHONE (HOME)		TELEPHONE (WORK)			ID NUMBER	DA Y OF BIRTH (*Month, Day, Year)*	AGE
AREA CODE	NUMBER	AREA CODE	NUMBER	EXT.			

RACE						EDUCATION (*Last grade completed)*	OCCUPATION			
	WHITE		HISPANIC WHITE		AMERICAN INDIAN / ALASKA NATIVE			HOMEMAKER		OUTSIDE WORK
	BLACK		HISPANIC BLACK		ASIAN / PACIFIC ISLANDER			STUDENT		

MARITAL STATUS						TYPE OF WORK
	SINGLE		MARRIED		WIDOWED	
	DIVORCED		SEPARATED			

HUSBAND/FATHER OF BABY		EMERGENCY CONTACT	TELEPHONE	
NAME	TELEPHONE		AREA CODE	NUMBER
	AREA CODE / NUMBER	NEWBORN'S PHYSICIAN	REFERRED BY	

FINAL ESTIMATED DELIVERY DATE	HOSPITAL OF DELIVERY	PRIMARY PROVIDER/GROUP	MEDICAID NUMBER/INSURANCE

NUMBER OF PREGNANCIES

TOTAL	FULL TERM	PREMATURE	ABORTIONS INDUCTED	ABORTIONS SPONTANEOUS	ECTOPIC	MULTIPLE BIRTHS	LIVING

PAST PREGNANCIES

DATE (MO/YR)	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX		TYPE DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR DELIVERY		COMMENTS / COMPLICATIONS
				F	M				YES	NO	

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD				MENSES			FREQUENCY				MENARCHE	
	DEFINITE		APPROXIMATE (MONTH KNOWN)	MONTHLY		PRIOR (Date)	(Days)	ON BCP AT CONCEPT			AGE ONSET	hCg +(Date)
	UNKNOWN		NORMAL AMOUNT/DURATION		YES				YES	NO		
	FINAL:				NO							

SYMPTOMS SINCE LAST MENSTRUAL PERIOD

DESCRIBE ALL SYMPTOMS

Missed periods	Mood swings	Cramping	Nausea	Increased vaginal discharge _____
Frequent urination	Headaches	Nasal stuffiness	Fatigue	Round ligament discomfort _____
Lightheaded/dizzy	Food cravings	Food aversions	Increased perspiration	Sore/tender breasts/nipples _____

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART/SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name – last, first, middle; ID No. or SSN; Sex)*		REGISTER NO.	WARD NO.

PRENATAL AND PREGNANCY
Medical Record

STANDARD FORM 533 (Rev. 12-1999)
Presented by GSA CMR FPMR 141 CFR 101.11.200

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PAST MEDICAL HISTORY

ITEM	O NEG POS	DETAIL POSITIVE REMARKS (include Date and Treatment)	ITEM	O NEG POS	DETAIL POSITIVE REMARKS (include Date and Treatment)
DIABETES			PULMONARY (TB, ASTHMA)		
HYPERTENSION			ALLERGIES (DRUGS)		
HEART DISEASE			BREAST		
AUTOIMMUNE DISORDER			HISTORY OF ABNORMAL PAP		
KIDNEY DISEASE/UTI			UTERINE ANOMALY / DES		
PSYCHIATRIC			INFERTILITY		
NEUROLOGIC / EPILEPSY			RELEVANT FAMILY HISTORY		
HEPATITIS / LIVER DISEASE			GYN SURGERY		
VARICOSITIES / PHLEBITIS					
THYROID DYSFUNCTION			OPERATIONS / HOSPITALIZATIONS (Year and Reason)		
TRAUMA / DOMESTIC VIOLENCE					
HISTORY OF BLOOD TRANSFUSION			ANESTHETIC COMPLICATIONS		
D (RH) SENSITIZED			OTHER (*Specify)*		

USE OF TOBACCO			USE OF ALCOHOL			USE OF STREET DRUGS		
NUMBER OF CIGARETTES PER DAY		NO. OF YEARS SMOKED	NUMBER OF DRINKS PER DAY		NO. OF YEARS DRINKING	AMOUNT PER DAY		NO. OF YEARS USE
PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW	

COMMENTS/COUNSELING

GENETICS SCREENING/TERATOLOGY COUNSELING
(*Includes Patient, Baby's Father, or anyone in Either Family)*

ITEM	YES	NO	ITEM	YES	NO
PATIENT'S AGE IS GREATER THAN 35 YEARS			MENTAL RETARDATION/AUTISM		
THALASSEMIA (ITALIAN, GREEK, MEDITERANEAN, OR ASIAN BACKGROUND (MCV IS LESS THAN 80)					
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANENCEPHALY			IF YES, WAS PERSON TESTED FOR FRAGILE X		
			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
CONGENITAL HEART DEFECT			MATERNAL METABOLIC DISORDER (EG, INSULIN DEPENDENT DIABETES, PKU)		
DOWN SYNDROME					
TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIANS)			PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)					
HEMOPHILIA			MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
MUSCULAR DYSTROPHY					
CYSTIC FIBROSIS			IF YES, LIST AGENT(S)		
HUNTINGTON CHOREA					
RECURRENT PREGNANCY LOSS OR STILLBIRTH			ANY OTHER		

COMMENTS/COUNSELING

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66, the proponent agency is the Office of the Surgeon General

REPORT TITLE	OTSG APPROVED (Date) (YYYYMMDD)

What topic does the patient want education on? Pregnancy

What is the easiest way for the patient to learn? ☐ Listening ☐ Pictures ☐ Demonstration ☐ Other: _____

Identified difficulty with reading ☐ Yes ☐ No

Cognitive: Exhibits ability to grasp concepts & responds to questions? ☐ Good ☐ Initiated

Physical barriers: ☐ none ☐ vision ☐ hearing ☐ language ☐ comment: _____

Emotional barriers: ☐ none ☐ anxiety ☐ denial ☐ depression ☐ comment: _____

Religious and/or cultural barriers: ☐ none ☐ comment: _____

Readiness to learn: exhibits readiness to learn? ☐ Yes ☐ No

Date & initial when initiated	*Learning objectives* OB History Class	Date & initial when met	Patient response
	1. The patient will be able to name 2 food groups.		
	2. The patient will be able to state 2 reasons to call the clinic.		
	3. The patient will be able to identify whom to call for after hours/emergency care.		
	4. The patient will be able to state why using alcohol, tobacco, or illicit drugs are harmful during pregnancy.		
	I give permission for consults YES NO		
	I understood the class YES NO		
	I hereby authorize the release of medical information relevant to this referral to the following Patient signature: Date:		
	Objectives needing review or reinforcement:		

PREPARED By (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give Name-last, first, middle; grade; date; hospital or medical facility)	
	HISTORY/PHYSICAL FLOW CHART OTHER EXAMINATION OR EVALUATION OTHER (Specify) DIAGNOSTIC STUDIES TREATMENT

DA FORM 4700, FEB 2003 EDITION OF MAY 78 IS OBSOLETE **FC MEDDAC OP 1458 (SEPT 98)**

MCXE FORM OB-GYN-40-3x (6) JUNE 2008

Preterm Risk Evaluation

MAJOR RISK FACTORS

	YES	NO
1. Have you ever delivered more than one month early?	_____	_____
2. Have you ever had premature labor and delivered one or more months early?	_____	_____
3. Do you have a fibroid or other abnormality of the uterus (not just a tipped uterus)?	_____	_____
4. Did your mother take the hormone DES (diethyl-Stillbesterol) while she was pregnant with you?	_____	_____
5. Have you ever had a cone biopsy or partial removal of your cervix?	_____	_____
6. Have you had two or more miscarriages and/or abortions at later than 3 months of pregnancy?	_____	_____

DID YOU HAVE ONE OR MORE YES ANSWERS TO QUESTIONS 1-6?

_____ _____

MINOR RISK FACTORS

	YES	NO
7. Have you had 1 miscarriage and/or abortions at later than 3 months of pregnancy?	_____	_____
8. Have you had 3 or more miscarriages and/or abortions In the first 3 months of pregnancy?	_____	_____
9. Do you smoke cigarettes?	_____	_____
10. Are you less than 18 years old?	_____	_____

DID YOU HAVE 2 OR MORE YES ANSWERS TO QUESTIONS 7-10?

_____ _____

Describe any “Yes” answers

MEDICAL RECORD-SUPPLEMENTAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE Obstetric Screening Questionnaire	OTSG APPROVED (Date) (YYYYMMDD)

Please circle if anyone in your family or partner's family have had these conditions:

1. Do you or the baby's father have a birth defect?	Yes/No
2. Do you or your partner have any health problems? Describe:	Yes/No

For the patient only:

3. Have you had an amniocentesis/CVS before?	Yes/No
4. Have you ever experienced preterm labor?	Yes/No
5. Has anyone in your family been referred for a genetic evaluation? Why?	Yes/No
6. Have you or your partner been exposed to any hazardous chemicals or environmental toxins?	Yes/No
7. Have you had any x-rays during this pregnancy? Describe:	Yes/No
8. Have you had any bleeding, spotting, leakage of fluid? Describe:	Yes/No
9. Have you had any unusual maternal illness during this pregnancy?	Yes/No
10. Have you taken any medication (including dietary supplements, herbs or over-the-counter) in this pregnancy? How much and when?	Yes/No
11. Do you have any body piercings or tattoos?	Yes/No
12. Have you been emotionally or physically abused by your partner or someone important to you?	Yes/No
13. Within the last year, have you been hit, slapped, kicked, pushed, shoved or otherwise physically hurt by your partner or ex-partner?	Yes/No
14. Does your partner ever force you into sex?	Yes/No
15. Are you afraid of your partner or ex-partner?	Yes/No
16. Have you ever had Chicken Pox or been vaccinated for Chicken Pox?	Yes/No

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINCI	DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give Name-last, first, middle; grade; date; hospital or medical facility)	HISTORY/PHYSICAL	FLOW CHART
	OTHER EXAMINATION OR EVALUATION	OTHER
	DIAGNOSTIC STUDIES	
	TREATMENT	

EVANS ARMY COMMUNITY HOSPITAL

ADVANCE DIRECTIVE PATIENT INFORMATION

1. I understand that Evans Army Community Hospital provides a Patient Representative. This representative is available to ensure my rights as a patient; to review any complaints I may have and when possible, resolve my complaints.

_____
(Patient's/Guardian's Initials)

2. I understand that as a patient; informed collaboration with my physician, I may expect to make a decision regarding my care, including the right to accept or refuse medical or surgical treatment and to be informed of any consequences. I also may formulate Advance Directives; however, I am not required to have an Advance Directive in order to receive care.

_____
(Patient's/Guardian's Initials)

3. I understand that the terms of any Advanced Directive that I execute will be followed by Evans Army Community Hospital to the extent permitted by law and in accordance with this facility's policies and procedures.

_____
(Patient's/Guardian/s Initials)

4. Please initial at least one of the following:

I have executed an Advance Directive for healthcare. I understand that it is my responsibility to provide this facility with a copy. I further understand that the staff and physicians of Evans Army Community Hospital will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

Type of Advance Directive:

_____ Living Will

_____ Durable Power of Attorney for Healthcare

_____ I have not executed an Advance Directive and do NOT wish to discuss Advance Directive at this time.

_____ I have not executed an Advance Directive, but would like additional information about Advance Directives.

5. I have revoked a previous Advance Directive:

Date revoked:

_____ Living Will

_____ Durable Medical Power of Attorney

_____ _____ _____ _____

Patient's/Guardian's Initials Date Witness Date

FC MEDDAC 1061, OCT 93

MEDICAL RECORD – CONSENT FORM

Cystic Fibrosis Carrier Test

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the cystic fibrosis carrier test. This test can identify if someone is a carrier of this disease.

By signing below I understand that—

1. This test is to see if I am a carrier of cystic fibrosis (CF). This means I could have the gene but not the disease.
2. The risk of being a CF carrier depends on race and ethnic background.
   a. For European Caucasian and Ashkenazi Jewish couples:
      (1) There is a 1 in 25 chance one parent is a carrier.
      (2) There is a 1 in 625 chance both parents are carriers.
   b. For Hispanic American couples:
      (1) There is a 1 in 46 chance one parent is a carrier.
      (2) There is a 1 in 2,116 chance both parents are carriers.
   c. For African American couples:
      (1) There is a 1 in 65 chance one parent is a carrier.
      (2) There is a 1 in 4,225 chance both parents are carriers.
   d. For Asian American couples:
      (1) There is a 1 in 80 chance one parent is a carrier.
      (2) There is a 1 in 8,100 chance both parents are carriers.
3. If I am a carrier of CF, testing the baby's biological father is needed to know if my baby could have CF.
4. CF carrier testing is one type of DNA testing. In the event the father is determined to be another person, a family medical history from that person will be necessary.
5. If both parents are carriers, the baby has a 1 in 4 (25%) chance of having CF. If this is the case, I may have more More testing to tell whether my baby has CF. This testing may be done before or after delivery.
6. I am the one to decide whether or not I am tested.
7. The test is not perfect. Some carriers are missed by the test.
8. My decision to have or not have this test will not change my military health coverage.

I have read and understand the information provided to me about cystic fibrosis. My questions have been answered to my satisfaction. Please check one:

☐ Yes, I want to have the cystic fibrosis carrier test.

☐ No, I do not want to have the cystic fibrosis carrier test.

Patient: _____ _____ _____
(Signature) (Print Name) (Date)

Witness: _____ _____ _____
(Signature) (Print Name) (Date)

MEDICAL RECORD – SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent is the Office of the Surgeon General.

REPORT TITLE	OTSG APPROVED (Date) (YYYYMMDD)
Consent Form Maternal Serum Analyte Screen	

I understand that I am being asked to decide whether or not to have a Maternal Analyte Screen. The Maternal Analyte Screen tests the mother's blood for substances made by baby and the placenta. The amount of these substances in the blood, plus the maternal age is used to calculate the risk of certain problems with the baby including open neural tube defects. Down's Syndrome (Trisomy 21), and Edwards Syndrome (Trisomy 18). By signing below, I show that I have been told what this test can and cannot do and that my questions were answered to my satisfaction.

By signing below I understand that:

1. This is a screening test only. IT DOES NOT provide a diagnosis; rather, it predicts the chance of a problem occurring.

2. The Maternal Serum Analyte Screen tests for an increased risk of baby with certain birth defects such as an open neural tube birth defects, Down's Syndrome, Edwards Syndrome, and other related birth defects.

3. The Maternal Serum Analyte Screen is not 100% accurate and is often abnormal when, in fact, the developing baby does not have one of these birth defects.

4. Open Neural tube defects are abnormalities of the spinal cord or brain and occur in 1 or 2 out of every 1000 births. Overall, if I have an abnormal result on the Maternal Serum Analyte Screen, my baby has only a 4 – 7 % risk of open neural tube defects.

5. Babies with Down's Syndrome have a distinct physical appearance, mental retardation, and are at increased risk for other birth defects. About 1 in 800 babies are born with Down's Syndrome (Trisomy 21), and the risk increases with the age of the mother. Overall, women with an abnormal test result; the baby has less than 3% risk of having Down's Syndrome.

6. Babies with Edwards Syndrome (Trisomy 18) have serious mental and physical disabilities. Only 1 out of 10 affected babies live past the first year. Only 1 in 8000 babies are born with Edwards Syndrome and the risk increases with the age of the mother.

7. I am the one to decide whether or not I am tested.

8. As noted above, the test is not perfect. Some defects are missed and there are many abnormal Maternal Serum Analyte Screen results that turn out to have no association with birth defects. If there are abnormal results, I will need further testing to determine if anything is wrong with my baby.

I have read and understand the information provided to me about Maternal Serum Analyte Screen and have had my questions answered to my complete satisfaction.

I (circle one) **would** or **would not** like to have the Maternal Serum Analyte Screen.

Patient: _____ Witness: _____

(print name) (print name)

_____ _____

(signature) (signature)

_____ _____

(date) (date)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give Name-last, first, middle; grade; date; hospital or medical facility)	☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT ☐ FLOW CHART ☐ OTHER (Specify)

DA FORM 4700, FEB 2003 EDITION OF MAY 78 IS OBSOLETE

MCXE FORM OBG-MBU 40-3x (12) NOV 2004

PRIVACY ACT STATEMENT

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031, and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by the Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state, and local agencies; compile statistical data; conduct research; teach; determine stability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

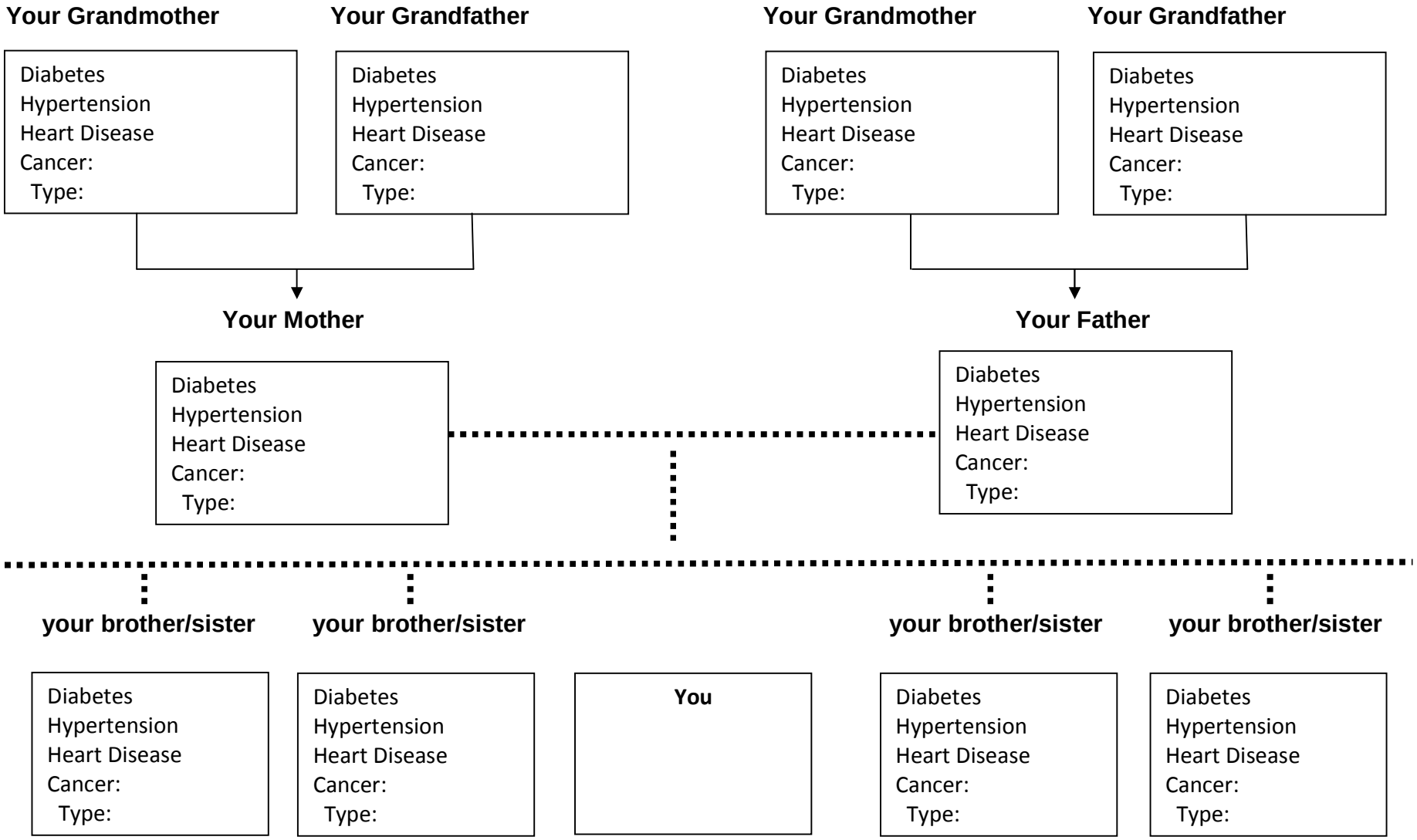
This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

Pregnant Patient Family Health Tree

Please circle any conditions listed that the family member has or did have.
If cancer, please indicate the type (breast, cervical, ovarian, lung, prostate, liver, etc).
If diabetes, please indicate: uses insulin, oral hypoglycemic, diet controlled.



THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0704-0323
OMB approval expires
Mar 31, 2013

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1095 and 1079b; Executive Order 9397.
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.
ROUTINE USE(S): In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, the information on this form will be released to your insurance company.
DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	**2. SSN**	**3. DATE OF BIRTH** *(YYYYMMDD)*
4a. MAILING ADDRESS (*Include ZIP Code)*	b. HOME TELEPHONE NO. ( )	
	5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN
6a. PATIENT'S EMPLOYER NAME	b. EMPLOYER TELEPHONE NUMBER ( )	

INSURANCE INFORMATION

7. DO YOU HAVE OTHER HEALTH INSURANCE? I(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)

- ☐ a. **YES** (*Complete Item 8 and the remaining sections below.)*
- ☐ b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid (*Proceed to Item 12.)*
- ☐ c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 11.)*

8. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER (*Last, First, Middle Initial)*	b. DATE OF BIRTH (YYYYMMDD)	c. RELATIONSHIP TO POLICY HOLDER
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER		
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYYMMDD)*	m. POLICY END DATE *(YYYYMMDD)*

n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS, AND TELEPHONE NUMBER		
(2) Rx POLICY ID	(3) Rx BIN NUMBER	(4) Rx PCN NUMBER

9. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 10; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYYMMDD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYYMMDD)*	m. POLICY END DATE *(YYYYMMDD)*

n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER.

(2) Rx POLICY ID	(3) Rx BIN NUMBER	(4) Rx PCN NUMBER

10. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** (Proceed to 10c.-f.) ☐ b. **NO** *(Proceed to Item 12.)*

c. NAME *(Last, First Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYMMDD)*	f.RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYMMDD*	f.RELATIONSHIP TO POLICY HOLDER

11. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME
d. MEDICARE PART D NUMBER AND PLAN NAME		e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATING

12. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.
b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.
c. NON-DoD PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents, ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by third-party insurer.
d. NON-DoD MEDICARE PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles.
e. DoD BENEFICIARIES: I here acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided me and/or my family member.
f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

13a. PATIENT OR ADULT FAMILY MEMBER SIGNAUTRE	b. DATE *(YYYYMMDD)*
14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYYMMDD)*

15. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.
b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

16a. SIGNATURE *(Patient of Adult Family Member)*	*b. DATE* (YYYYMMDD)

17. VERIFICATION a. (1) DATE *(YYYYMMDD)*	(2) INITIALS	b.(1) DATE *(YYYYMMDD)*	(2) INITIALS	c.(1) DATE *(YYYYMMDD)*	(2) INITIALS

Centering Pregnancy® – What is it?

Centering Pregnancy® is a group model for prenatal care where 8 to 12 pregnant women who are all due around the same time meet together for their prenatal care. There are 9 group sessions during the pregnancy, each one lasting 2 hours. The group is led by one Certified Nurse Midwife and one other staff member. All of the usual parts of prenatal care are included in this model, including labs, ultrasound, and listening to the baby's heart beat. Because this model includes a group of women, it provides a fun way of learning and sharing that is not possible with one-to-one encounters. Women share their concerns and successes with each other, and develop a social network with other pregnant women.

Things to consider:

Are you staying in the Fort Carson area for your pregnancy and delivery?

Are you tired of spending time in the waiting room?

Would you like to see the same provider for each visit?

Would you like to know all the dates for all your appointments now?

Are you okay with not bringing your children to your visits?

Can you devote two hours to an OB visit/group?

Would you like to meet with other women who have due dates close to yours?

Is your pregnancy considered to be high risk?

Are you interested in receiving your care in a Centering Pregnancy® group? _____

Contact Information:

Name:_____ Sponsor SSN:_____

Phone number:_____

Due date:_____

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
1650 COCHRANE CIRCLE
FORT CARSON, COLORADO 80913-4604

REPLY TO
ATTENTION OF

MCXE –OBG

19 March 2013

MEMORANDUM FOR Patients Receiving Obstetrical Care (OB) at Evans Army Community Hospital

Subject: Late Arrival for OB Appointments Policy

1. Congratulations on your pregnancy. We look forward to giving you excellent prenatal care here in the OB/GYN Clinic at Evans Army Community Hospital.

2. Due to the large volume of pregnant women in the Pikes Peak Area of Operation, our clinic appointments are booked to full capacity each day. Your initial appointment with be a "New OB appointment" conducted with our OB education staff and is approximately 2 hours long. During this appointment the OB education staff will initiate your prenatal chart, conduct a history and go over how the OB clinic works.

3. After your New OB appointment, your first routine appointment with a provider will be 40 minutes and all remaining appointments are between 15 to 20 minutes long with a provider. If you have questions at your appointment, please be considerate of the patients after you and of our clinic time schedule limitations. Address your issues with your provider in a timely manner.

4. Unless medically indicated, additional ultrasounds will NOT be performed during routine appointments. Your anatomy ultrasound is performed with Radiology between 18-22 weeks.

5. Our clinic follows the DoD/VA Pregnancy Practice Guidelines for frequency of appointments, which include an initial 10-12 week New OB appointment, 16-20 week visit, 24 week visit, 28 week visit, 32 week visit, 36 week visit, 38 week visit, 39 week visit, 40 week visit, and 41 week visit, equating to 8-11 visits for uncomplicated pregnancies. Complicated pregnancies will require more frequent visits tailored to the medical condition.

6. We are constantly striving to improve our services in the OB Clinic. Recent research has shown that a major patient complaint is the time waiting to see a provider. As part of YOUR INITIATIVE to reduce wait times, we have instituted a LATE POLICY. Hospital policy states that patients should arrive 15 minutes prior to their appointment time. This policy allows you to be checked into the system, fill out necessary paperwork and have your vital signs obtained to ensure you see your provider in a timely manner.

7. If you are TEN minutes late for any OB appointment, you are considered LATE and will be given the option of rescheduling to another appointment that day if an open appointment remains, or on a different date. Alternatively, you may wait to be seen until your scheduled provider is finished seeing his/her other scheduled patients for that morning or afternoon. If you are more than 20 minutes late, you are a NO-SHOW and will be rescheduled in the next available appointment.

8. We thank you in advance for your cooperation and assistance in keeping our wait times to a minimum and improving our flow of patients.

9. I acknowledge receiving a copy of this policy and have signed below.

_____

Patient Signature and Date

ANTHONY SULLIVAN, M.D.
LTC, MC
Chief, Department of OB/GYN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE	OTSG APPROVED (Date) (YYYYMMDD)

What topic does the patient want education on? Pregnancy

What is the easiest way for the patient to learn? □ Listening □ pictures □ demonstration □ other: _____

Identified difficulty with reading? □ No □ Yes

Cognitive: Exhibits ability to grasp concepts& responds to questions? □ Good □ limited

Physical barriers: □ none □ vision □ hearing □ language □ comment: _____

Emotional barriers: □ none □ anxiety □ anger □ denial □ depression □ comment: _____

Religious&/or cultural barriers: □ none □ comment: _____

Readiness to learn: exhibits readiness to learn? □ Yes □ No

Date & initial when initiated	*Learning objectives* **OB History Class**	Date & initial when met	Patient response
	1. The patient will be able to name 2 food groups.		
	2. The patient will be able to state 2 reasons to call the clinic.		
	3. The patient will be able to identify whom to call for after hours/emergency care.		
	4. The patient will be able to state why using alcohol, tobacco or illicit drugs are harmful during pregnancy.		
	I give permission for consults YES NO		
	I understood the class YES NO		
	Patient signature:		
	Objectives needing review or reinforcement:		

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give Name-last, first, middle; grade; date; hospital or medical facility)	
	□ HISTORY/PHYSICAL □ FLOW CHART □ OTHER EXAMINATION OR EVALUATION □ OTHER (Specify) □ DIAGNOSTIC STUDIES □ TREATMENT